Complete Summary

GUIDELINE TITLE

Severe and persistent mental illness in HIV-infected patients.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Severe and persistent mental illness in HIV-infected patients. New York (NY): New York State Department of Health; 2007 Nov. 13 p. [10 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Severe and persistent mental illness (SPMI) in HIV-infected patients

GUIDELINE CATEGORY

Counseling
Diagnosis
Evaluation
Management
Risk Assessment
Treatment

CLINICAL SPECIALTY

Allergy and Immunology
Emergency Medicine
Family Practice
Infectious Diseases
Internal Medicine
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To provide guidelines for the treatment of severe and persistent mental illness in human immunodeficiency virus (HIV)-infected patients

TARGET POPULATION

Human immunodeficiency virus (HIV)-infected patients with severe and persistent mental illness

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Risk Assessment

1. Assessing for any treatable underlying medical or neurologic conditions
2. Assessing for positive and negative symptoms of psychosis
3. Assessing the risks for sexual abuse, unprotected sex, substance abuse, and violence

Management/Treatment

1. Emergency referrals for acute psychosis
2. Developing a treatment plan
3. Coordinating care with mental health provider
4. Psychotropic medications
5. Nonpharmacologic mental health management
6. Engaging and maintaining patients in care
7. Antiretroviral therapy
8. Risk reduction counseling
9. Substance use referral

MAJOR OUTCOMES CONSIDERED

- Rates of human immunodeficiency virus (HIV) infection among patients with severe and persistent mental illness
- Rates of adherence to antiretroviral therapy

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

AIDS Institute clinical guidelines are developed by distinguished committees of clinicians and others with extensive experience providing care to people with HIV infection. Committees* meet regularly to assess current recommendations and to

write and update guidelines in accordance with newly emerging clinical and research developments.

The Committees* rely on evidence to the extent possible in formulating recommendations. When data from randomized clinical trials are not available, Committees rely on developing guidelines based on consensus, balancing the use of new information with sound clinical judgment that results in recommendations that are in the best interest of patients.

* Current committees include:

- Medical Care Criteria Committee
- Committee for the Care of Children and Adolescents with HIV Infection
- Dental Standards of Care Committee
- Mental Health Committee
- Women's Health Committee
- Substance Use Committee
- Physician's Prevention Advisory Committee
- Pharmacy Committee

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

All guidelines developed by the Committee are externally peer reviewed by at least two experts in that particular area of patient care, which ensures depth and quality of the guidelines.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Acute Psychosis and Emergency Referrals

After excluding or treating urgent medical conditions, clinicians should refer patients in acute psychiatric distress and those with suicidal or violent ideation for immediate psychiatric evaluation.

Clinicians should be able to recognize the signs and symptoms of delirium and refer patients presenting with such symptoms immediately to the hospital.

Diagnosis of Severe and Persistent Mental Illness (SPMI)

Differential Diagnosis

Clinicians should assess patients for any treatable underlying medical or neurologic conditions, including those attributable to medications that could cause or exacerbate a mental health condition.

Diagnosis

Clinicians should refer patients for a psychiatric evaluation when patients present with symptoms of psychosis that are not attributable to delirium or dementia.

Treatment and Management of Patients with SPMI

Developing a Treatment Plan and Coordination of Care

Clinicians should investigate the mental health history of patients with SPMI and contact the last known treating psychiatrist.

Clinicians should determine whether patients with SPMI are receiving mental health care. For patients who are receiving mental health care, clinicians should coordinate with their mental health providers. If the patient is not receiving mental health care, the clinician should refer him/her for such care.

Clinicians and mental health care providers should collaborate to develop a step-by-step treatment plan that delineates the frequency of follow-up visits with both providers as well as the frequency of contacts between providers to reevaluate effectiveness of the overall medical and mental health treatment.

Patients with SPMI Who Refuse Psychiatric Care

Psychotropic Management

When managing psychotropic treatment of SPMI patients who refuse psychiatric care:

- The primary care clinician should consult with a psychiatrist within the healthcare team if available, both initially and if assistance is required over time, when prescribing or changing psychotropic medications
- If a psychiatrist is not available within the healthcare team, the primary care clinician should consider creating an ongoing "silent partnership" with a psychiatrist outside of the healthcare team that maintains the confidentiality of the patient's identity but enables the clinician to consult about the patient's psychotropic medications.

Nonpharmacologic Mental Health Management

When managing the nonpharmacologic aspects of mental health care for SPMI patients who refuse psychiatric care:

- The primary care clinician should consult with a licensed mental health professional within the healthcare team if available (e.g., psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse) on an ongoing basis, such as during team meetings, regarding the patient's treatment *but*
- If a mental health professional is not available for regular consultation within the team setting, the primary care clinician should consider creating an ongoing "silent partnership" outside of the healthcare team that maintains the confidentiality of the patient's identity but enables the clinician to consult with a licensed mental health professional.

Key Point:

According to Health Insurance Portability and Accountability Act (HIPAA) regulations, the patient's identity cannot be shared with the silent partner without the patient's consent in most cases. These regulations may vary according to the type of facility. For specific information about HIPAA, refer to the New York State Department of Health's HIPAA Information Center.

Engaging the Patient with SPMI in Care

Clinicians should attempt to engage human immunodeficiency virus (HIV)-infected patients with SPMI in a partnership of care.

Clinicians should not attempt to argue or change the delusional belief systems of patients with SPMI.

Clinicians should help all members of the staff develop and enhance their skills for working with patients with SPMI.

Key Point:

Attempting to show patients with SPMI the illogic of their beliefs is counterproductive in establishing a partnership in treatment and could ultimately frustrate both the clinician and patient.

Table. General Guidelines for Interacting with Patients with Severe and Persistent Mental Illness

- Become familiar with the person behind the illness; attempt to connect on a personal level.
- Keep in mind that patients with SPMI are rarely physically violent*; potential for violence should be assessed on a case-by-case basis.
- Be as straightforward as possible; do not be evasive or overly protective with medical information; the tendency of some patients with SPMI to be suspicious may be exacerbated by a clinician's evasiveness.

Table. General Guidelines for Interacting with Patients with Severe and Persistent Mental Illness
• Create a structured environment; patients with SPMI respond best when they know what is expected of them. • Do not try to change the belief systems of patients; delusional beliefs often do not prevent patients from understanding and following medical instructions. • Give them space; if they want to disengage in conversation, let them.

*The low incidence of violence applies to all disorders associated with SPMI. However, comorbid substance use increases the risk of violence in these patients (see the National Guideline Clearinghouse (NGC) summary of the New York State Department of Health (NYSDOH) guideline, Suicidality and Violence in Patients with HIV/AIDS).

Table. Maintaining the SPMI Patient in Care
• Assess patients' psychosocial status regularly—housing, employment and/or social security disability benefits, health insurance, family and partner contacts, stability of relationships, including domestic violence screening. • Ask follow-up questions of patients regarding mental health and treatment progress as a routine part of clinic visits. • Monitor interactions between patients' physical and mental conditions and the effects of psychotropic and other medications. • Make referrals to mental health care if the patient is not receiving mental health care. • Monitor adherence to recommended mental health treatment, including psychotropic medications, appointments with mental health providers, and attendance in support groups. • Include mental health diagnoses among other medical data, assessments, and plans. • Consider patients' mental status before prescribing antiretroviral (ARV) medications. • Maintain follow-up phone contact with patients' mental health treatment programs, including notifying programs of medication changes. • Monitor patients' potential barriers to adherence to ARV therapy when applicable (refer to the NGC summary of the NYSODH guideline, Adherence to Antiretroviral Therapy among HIV-Infected Patients with Mental Health Disorders).

Key Point:

Adherence to treatment can be enhanced when appointments are scheduled at times when the needs of patients with SPMI are best accommodated.

ARV Therapy and Adherence

Clinicians should initiate ARV therapy only after the patient's basic needs have been adequately addressed, including receipt of social support services and stabilization of mental status through effective treatment of psychiatric symptoms.

Clinicians should discuss potential side effects of psychotropic medications, as well as their potential interactions with ARV therapy and other medications. If side effects or interactions occur, clinicians and patients should discuss how they will be managed.

Clinicians should note all medications in the medical record, including psychotropic medications that patients with SPMI are receiving.

Risk Reduction Counseling and Substance Use Referral

Table. Identification and Management of Risk in Patients with SPMI

Risk	Management Recommendation
Coerced or forced sex	• Intensive risk-reduction counseling that includes skills training in detecting and avoiding situations that increase risk for sexual violence • Rape crisis services* when patients present immediately after an episode of coerced sex • Referral for domestic violence services when appropriate
Inconsistent use of barrier protection	• Intensive risk-reduction counseling, including the importance of effective barrier protection to avoid HIV transmission
Trading sex for money or drugs	• Assistance with applying for benefits for food and housing and other services for which they might be eligible to reduce the likelihood of trading sex • Intensive risk-reduction counseling, including the importance of effective barrier protection to avoid HIV transmission • Referral for substance use treatment; in particular, injection drug users enrolled in methadone or buprenorphine programs are less likely to engage in high-risk behaviors such as unprotected sex or needle sharing; they are also more likely to adhere to HIV-related treatment and medication regimens**

*Examples of such services include crisis counseling and emergency contraception.

** Refer to the NGC summary of the NYSDOH Substance Use Guideline, Working with the Active User.

Sexual Risk Behaviors

Clinicians should determine whether sexually active patients with SPMI have experienced or are at risk for coerced or forced sex.

Clinicians should educate patients, including those with SPMI, about safe-sex practices when discussing HIV risk reduction.

Substance Use

Clinicians should make appropriate referrals, including consulting a mentally ill chemical abuser (MICA) specialist, when substance use disorders are identified in SPMI patients.

Clinicians should screen all HIV-infected patients for past and present substance use at baseline and at least annually.

Patients at Risk for Violence

Clinicians should clearly instruct medical support staff about how to manage emergencies involving patients with potential or actual violent behavior toward self or others.

Mental Health Services and Programs

Clinicians should have access to information regarding follow-up for patients with SPMI, including assisted outpatient treatment and intensive case management, which can be obtained by calling 1-800-HEALTHNET.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and treatment of severe and persistent mental illness in human immunodeficiency virus (HIV)-infected patients

POTENTIAL HARMS

Potential side effects of psychotropic medications and their potential interactions with antiretroviral therapy

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The AIDS Institute's Office of the Medical Director directly oversees the development, publication, dissemination and implementation of clinical practice guidelines, in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines address the medical management of adults, adolescents and children with HIV infection; primary and secondary prevention in medical settings; and include informational brochures for care providers and the public.

Guidelines Dissemination

Guidelines are disseminated to clinicians, support service providers and consumers through mass mailings and numerous AIDS Institute-sponsored educational programs. Distribution methods include the HIV Clinical Resource website, the Clinical Education Initiative, the AIDS Educational Training Centers (AETC) and the HIV/AIDS Materials Initiative. Printed copies of clinical guidelines are available for order from the New York State Department of Health (NYSDOH) Distribution Center for providers who lack internet access.

Guidelines Implementation

The HIV Clinical Guidelines Program works with other programs in the AIDS Institute to promote adoption of guidelines. Clinicians, for example, are targeted through the Clinical Education Initiative (CEI) and the AETC. The CEI provides tailored educational programming on site for health care providers on important topics in HIV care, including those addressed by the HIV Clinical Guidelines Program. The AETC provides conferences, grand rounds and other programs that cover topics contained in AIDS Institute guidelines.

Support service providers are targeted through the HIV Education and Training initiative which provides training on important HIV topics to non-physician health and human services providers. Education is carried out across the State as well as through video conferencing and audio conferencing.

The HIV Clinical Guidelines Program also works in a coordinated manner with the HIV Quality of Care Program to promote implementation of HIV guidelines in New York State. By developing quality indicators based on the guidelines, the AIDS Institute has created a mechanism for measurement of performance that allows providers and consumers to know to what extent specific guidelines have been implemented.

Finally, best practices booklets are developed through the HIV Clinical Guidelines Program. These contain practical solutions to common problems related to access, delivery or coordination of care, in an effort to ensure that HIV guidelines are implemented and that patients receive the highest level of HIV care possible.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Severe and persistent mental illness in HIV-infected patients. New York (NY): New York State Department of Health; 2007 Nov. 13 p. [10 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2007 Dec

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

GUIDELINE COMMITTEE

Mental Health Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Chair: Milton L Wainberg, MD, New York State Psychiatric Institute, New York, New York

Members: Bruce D Agins, MD, MPH, New York State Department of Health AIDS Institute, New York, New York; Kalyana Battu, MD, Albany Medical Center, Albany, New York; Barbara A Conanan, RN, MS, Saint Vincent's Manhattan Department of Community Medicine, New York, New York; Joseph Z Lux, MD, Bellevue Hospital, New York, New York; Peter Meacher, MD, AAHIVS, FAAFP, South Bronx Health Center for Children and Families, Bronx, New York; Yiu Kee Warren Ng, MD, New York Presbyterian Hospital, Columbia University Medical Center, New York, New York; Bella M Schanzer, MD, MPH, Columbia University Medical Center, New York, New York

Liaisons: Francine Cournos, MD, Liaison to the New York/New Jersey AIDS Education and Training Center, Columbia University, New York State Psychiatric Institute New York, New York; James J Satriano, PhD, Liaison to the New York State Office of Mental Health, Columbia University College of Physicians and Surgeons, New York, New York

AIDS Institute Staff Liaison: L Jeannine Bookhardt-Murray, MD, Harlem United Community AIDS Center, New York, New York

AIDS Institute Representative: Heather A Duell, LMSW, New York State Department of Health AIDS Institute, Bureau of Community and Support Services, Albany, New York

Principal Contributor: James J Satriano, PhD, Columbia University College of Physicians and Surgeons, New York

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Mental health screening: a quick reference guide for HIV primary care clinicians. New York (NY): New York State Department of Health; 2006 Feb. 2 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

This guideline is also available as a Personal Digital Assistant (PDA) download from the New York State Department of Health AIDS Institute Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on July 3, 2008.

COPYRIGHT STATEMENT

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 9/15/2008